KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT
BILL GRAVES, GOVERNOR
Clyde D. Graeber, Secretary

June 19, 2002

SUBMITTED ELECTRONICALLY

Marlene H. Dortch
Secretary
Federal Communications Commission
445 12TH Street, S.W.
Washington, DC 20554

Dear Ms. Secretary,

We appreciate the opportunity to comment on the Commission's proposed rulemaking for the Rural Health Care Support mechanism. We believe the following changes to the program would greatly benefit rural areas of our state.

1. **INCLUDE internet monthly service charges in the program.** Rural health care providers, like other providers, increasingly rely on the Internet for standard communications and business functions. Regulatory information, program announcements, epidemiology alerts, and a wide array of information is available to rural providers in a timely method through the use of the Internet. Web-based applications also are increasingly used for filing electronic claims and for other crucial business functions, and telemedicine and telehealth are increasingly important in rural America.

2. **ADD nursing homes, long-term care facilities, home health and hospice in the discount program as eligible entities.** In Kansas and other rural states long-term care is an increasingly crucial sector in the health care services arena, as rural populations become older. In Kansas, for instance, while the elderly population averages 14% statewide, the population 65 or older in rural and frontier counties averages 21%. Long-term care will continue to grow, and these facilities need to be part of integrated delivery systems in rural areas, systems that rely on telecommunications infrastructure for efficient operations.

3. **ADD ambulance services in the discount program as eligible entities.** Emergency Medical Services (EMS) are a crucial part of the "safety net" in rural America, and would be a critical part of the "first responder" system in the event of terrorist incidents, such as biological and chemical threats, in our country. In Kansas, efforts are being made to more fully integrate EMS services into rural health networks to allow EMS to be a full partner in the seamless

delivery of healthcare. Perhaps a mechanism for inclusion of EMS would be to allow the inclusion of ambulance services that are part of a consortium eligible as a "health care provider."

4. **CHANGE the calculation method to figure the discount**. We believe the Maximum Allowable Distance (MAD) requirements should be dropped, so that rural areas near to urban areas of more than 50,000 residents are not unfairly disadvantaged, as they are using the current requirements. We believe addressing the MAD requirements would simplify the system and encourage greater utilization of the program by qualified applicants.

5. **ALLOW comparison with rates in any city in a state, and not just the closest city of 50,000, for rate comparison.**

6. **STREAMLINE the application process, eliminating Form 468 entirely.** It is our understanding that telephone companies have struggled with completing Form 468, and it appears that elimination of this form would cut the application process time significantly.

7. **ALLOW facilities with telecommunication contracts in place to apply for the Rural Health Care Support program.** Often in the rural areas, there is only a single telecommunication service provider, and if there are multiple providers, health care providers most likely used some type of competitive bidding process to select a preferred telecommunication service provider. Additionally, in order to receive cost-effective rates, health care providers often enter into multi-year contracts with their telecommunication service provider. The fact that a health care provider has already taken these steps to reduce their telecommunications costs thereby makes them ineligible under the current rules for the Universal Service program.

8. **ELIMINATE the need to post the Form 465 for 28 days if only one telephone service provider exists in the area**, such that there is no competition for telecommunication services in the area. This would significantly speed the application process in areas where a single provider is available.

9. **CALCULATE discounts by comparing services based on functionality of the service from the perspective of the end user.** Currently the rules do not state how urban and rural services are compared, and therefore discounts are based on difference in urban and rural rates between the same or similar services. However, doing so does not take into account the fact that some less expensive services in urban areas may not be available in rural areas, and rural providers are thus required to seek out more expensive services.

10. **In cases where high speed land-based services are available, PROVIDE funding support to rural providers based on land-based rates.** Should providers opt for more expensive satellite-based services, provide funding at the level of available land-based services, giving the providers the opportunity to pay the difference should they opt for the more expensive service. Use of satellite services should be fully funded only in those areas where it is the only available service.

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11. **NOTIFY not only providers, but also applicable state agencies (such as State Offices of Rural Health, State EMS agencies, etc.) of changes in deadlines for application filings and other changes in application and appeals process.** These state agencies are often charged with the responsibility of providing a information clearinghouse/dissemination function. Partner with these state agencies to inform key rural constituents.

12. **RETAIN the current rule for pro-rata distribution of funds if total demand for support in a year exceeds the cap.**

13. **ENCOURAGE partnerships between health care providers, schools and libraries.** The current system encourages "silo" development of separate systems developed for rural health care providers, schools and libraries. In many communities, cost sharing of a T-1 or T-3 line would be more effective and cost-efficient.

14. **ADOPT the definition of rural utilized by the Department of Health and Human Services Office of Rural Health Policy (ORHP).** ORHP's definition has changed since the FCC's Report and Order on Universal Service of May 7, 1997. When the OMB rolls the 2000 census into their MSA definition, this could present eligibility complications, and health care providers could qualify as rural under one federal program but not others.

15. **Simplify future NPRM comment procedures.** The required process for commenting on this NPRM is far too time-consuming and complicated for the average consumer. To use the email form, for example, one must first complete an online form, then save the form to a file, and the email it or mail it to your contract0r, Qualex International. To mail comments through normal mail requires sending multiple copies as well as a specifically labeled diskette (in "read only" mode) to your commission and to the FCC contractor. If the FCC wants comments from typical "end users," this process must be simplified.

In today's health care system, providers increasingly need timely access to information to provide the highest quality health care. Information pertaining to administrative and clinical needs in health care is increasingly being offered through electronic means. In Kansas, for example, two new systems, the Public Health Information Exchange (PHIX), and the Kansas Rural Health Information Service, are being developed to provide timely information to rural providers. The PHIX system will provide critical, time sensitive information on infectious disease threats and other public health issues to providers across the state.

Quality access to telecommunications services, including Internet access, are key for effective utilization of these types of systems. Unfortunately, many health care providers are currently unaware of the program, and health care providers and telecommunications companies alike have problems with the current applications process, which is often complex and confusing. This results in a low rate of application by eligible providers. The Rural Health Care Support Mechanism should be modified to allow the greatest level of participation and support that the program is capable of.

Sincerely,

Richard J. Morrissey
Director

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